FLORIDA
PSYCHOLOGICAL

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____Phone #:_____

Address: _____ Email Address:_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, as a client or legal representative, authorize Florida Psychological to release the following:

_____ Diagnostic Evaluation Results
_____ Treatment Summary
_____ Med. Mgt. Progress Notes
_____ Treatment Plan
_____ Discharge Reports
_____ Other: _____

The above information is only to be released to the following party:

Name and/or Agency: _____ Phone: _____ Fax: _____

This information is to be used for: ☐ Communication ☐ Medical Records

ACKNOWLEDGEMENT

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I also understand that I have the right to examine and copy the information disclosed.

Signature of client/legal representative: _____ Date: _____

Printed name: _____ Relationship to client: _____

You may refuse to sign this authorization.

This release will remain in effect until one year from date of signature at which time it shall expire and no further release of information shall be made under its terms.

Per Florida Statute 394.4615, clients shall have reasonable access to their Medical Records unless such access determined by the client's physician to be harmful to the client.

*Behavioral healthcare records are protected under the Federal regulations governing Confidentiality and Drug Abuse Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164.PP

Please email this form to Customerservice@Floridapsy.com

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